WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	☐ Male ☐ Female	Birthdate	Phone Number	Employee E-mail
Address		City	State	Zip Code
EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)	
Address		Phone Number	Employer FEIN	
City	State	Zip Code	Employer E-mail	
INSURER / SELF-INSURER	Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #	
CLAIMS OFFICE	Name	Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
SBWC ID# (five digit no.)	Address	City	State	Zip Code

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ☐ per Hour ☐ per Day ☐ per Week ☐ per Month
Insurer Type Code ☐ I – Insurer ☐ S-Self-insurer ☐ G-Guarantee Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ☐ am ☐ pm	County of Injury	Date Employer had knowledge of Initial Disability	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? ☐ Yes ☐ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address)	Initial Treatment Given: ☐ None ☐ Minor: By Employer ☐ Minor: Clinical/Hospital ☐ Emergency Room ☐ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: / Returned at what wage per Week / If Fatal, Enter Complete Date of Death

Report Prepared By (Print or Type)	Telephone Number	Date of Report

B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability: _____

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

☐ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of ____ % to _____ for ____ weeks.

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

D. MEDICAL ONLY INJURY ☐ No disability paid or controverted

(Insurer / Self-Insurer: Type or Print Name of Person Filling Form)	Signature	Date

Phone and Ext.	E-mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).